The PREVENTION CONNECTION
NEWSLETTER

Parenting Connected Children

—Elizabeth Kohlstaedt, Ph.D.

—It is a solemn responsibility and the greatest joy to raise a child. How that child is parented in his first three years has life-long ramifications . . . for the child and for society as a whole.

Even in the womb, the fetal brain is wiring up to the experience of the mother. The brain stem is like the metronome for the baby's arousal level. If there is danger, regular high levels of stress, or drugs that elevate the mother's heart rate, the fetal nervous system starts out as "tuned up" and may yield a difficult-to-soothe infant. On the other hand, if the mother is calm and regulated, well cared for and experiencing few major stressors, the baby's brain stem begins to regulate as mom regulates.

From birth, the infant orients toward the mother, toward her voice and smell. The wiring of the baby's brain is shaped in the first three years of life by the mother . . . and the *mother's* brain is shaped by the baby's response. We have all heard that special "mother voice" reserved for cooing to the infant; we've all seen that special look in a mother's eyes when she meets the eyes of her infant. D.W. Winnicot, a pediatrician, believed that the mother/child matrix—baby's need and mom's response to that need—is what produces a regulated human being. The baby finds itself (for good or ill) in the reflection of the mother's eyes. If those eyes are loving, joyful and responsive, then the infant's core emotional responses are joyful and satisfied. If mom's eyes are angry or flat, unexpressive or unattuned, the infant's core sense of himself is negative and angry. To a great extent, how the infant is cared for and the level of security he experiences during his first three years determines how he views and interacts with the world as a child, teenager and adult.

According to Mary Ainsworth, Ph.D, an early researcher in attachment, the ideal mother is sensitive (aware of the infant's state), accepting (of whatever the infant is signaling), psychologically accessible (not so mired in her own needs that she can attend to infant's), and cooperative (can alter her response dependent on the infant's need). When the mother provides accurate and timely responses to reduce distress, the infant begins to calm in the mother's presence.

Life is seldom is as clear as the research. So what happens when the mother falls short of the ideal? Some researchers looked into "good-enough" mothering and found that *good enough mothers* accurately met the infant's needs 30 percent of the time and missed the cue 30 percent of the time (e.g., didn't hear the cry or gave the bottle instead of changing the diaper). The most critical 30 percent of the time, however, mothers repaired the relationship by noting that the infant was not soothed and changing the response to the one the infant needed.

Mothers who can regulate physiological arousal in the first year of life and modulate emotional arousal in the second and third years of life produce calm and regulated infants. If the infant feels secure in the presence of his mother and is certain that she will return if he is distressed, that is considered *secure attachment.* It is secure attachment that produces a child who can later explore, feel confident and learn well. The child will also be able to tolerate frustration, because frustration was not allowed to become overwhelming. Mary Ainsworth and her colleagues found that about 65 percent of a "normal" population have secure attachments.

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Early Childhood

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Who is providing the alcohol to underage drinkers? Most of the youth who are engaging in underage drinking are getting alcohol either from someone they know who is age 21 or older, someone they know who is under age 21, or at home, either with or without their parents' permission.

Parenting Connected Children

Continued from cover

About 15 percent of a normal population across cultures have *insecure attachments*, meaning the infant is not entirely sure of the mother's response when that response is most needed. Sometimes it's there, sometimes not . . . sometimes it's accurate, sometimes it's way off . . . sometimes mom is soothing, sometimes angry. In these cases (which are, again, a normal variation), infants find behaviors that organize the mother's response. As the infant becomes a toddler, he may turn away from the mother when she returns from a brief absence, or may fight and be angry with mother upon return. Even though these behaviors are upsetting, they have the effect of ensuring that the mother will return or, at least, find it more difficult to go away. Children with insecure attachments typically have lower frustration tolerance, less confidence and emotions that are less-well regulated.

The most disturbed and disturbing category of attachment is *disorganized attachment*. Infants traumatized by the very person they must turn to for security don't know whether to move toward the caregiver for help or away because of associated hurt. Even before language develops, an infant exposed to violence from the mother or between the parents will experience the trauma as if it were happening to him. That infant is "wiring in" to the tension, fear, rage and terror of the violence between adults. This wiring goes to the deepest part of the brain and the baby becomes activated, supersensitive to noise, terrified and overwhelmed with fear. Much later, after the threat is gone and he has grown, the brain stem will continue to remain activated and on alert for danger. This can look like attention deficit disorder—scanning the environment, hypersensitive to noise and sound, restless and unfocused movement.

For infants, fathers are important in terms of their ability to help the mother regulate her affect so that she can regulate the baby's arousal. Creation of security and stability is vital. The father's attachment to the baby is different than the mother's and seems to fulfill a different function. The mother's attachment tends to regulate and modulate arousal, while the father's tends to be more stimulating and educative. Both are important. Infants need regulation and modulation as well as stimulation for optimum growth and development.

Alan Schore, Ph.D., a researcher and clinician in the field of attachment, noted that the percentage of secure attachments in the US is decreasing and the percentage of insecure attachments is on the rise. If that is the case, clearly something we're doing isn't working well for our children. Bruce Perry, MD, Ph.D. has written of his concerns about the relational poverty of the American culture. We live in small nuclear families, often far from extended family caregivers. We get divorced, fight over who has the right to keep the child and then move children back and forth across environments. In more extreme cases, we move children from foster home to foster home. All of that anger, tension, loss and environmental change have an effect. The younger the child, the more likely the tension and uncertainty will become wired into the brain as a model of what life is like.

Children's brains form around patterned repetitive responses in relationships. If those repetitive responses are filled with hostility or anger (even if it is anger projected toward someone else), the baby's brain wires in at its deepest levels that this is what life is, so be prepared. If inconsistency in the environment and unstable relationships are patterned, repetitive responses, the infant is less secure. What is learned in the first three years of life cannot be unlearned by short-term experiences or kind words. Children who have been harmed in early life will always have some vulnerability, some of which is physical. Researchers from Kaiser-Permanente conducted a series of studies on adverse childhood events. Across several studies, these researchers demonstrated that the experience of ten separate adverse events of childhood was cumulative in effect—the more adverse events a child experiences, the more likely that the person will contract life-threatening adult diseases such as heart disease, cancer or diabetes. Thus, how we raise children not only determines the child's *emotional* success or failure, but also has strong effects on the child and adult's physical well-being or illness.

—Elizabeth Kohlstaedt, Ph.D. is the Clinical Director for Intermountain , a nationally recognized Montana non-profit specializing in nurturing, therapeutic environments for children under severe emotional distress. For more information,visit www.intermountain.org or call 406.442.7920.

Best Beginnings:
Early Years are Learning Years

—Libby Hancock

—What do all children need in the first years of life to thrive, grow and learn? How do we meet those needs for all children regardless of where they spend their days—child care, Head Start, Early Head Start, preschool, or with family, friends or neighbors?

These questions have been central to the work of Montana's Early Childhood Project for more than two decades. Research provides solid answers and yet there are still young children slipping through the cracks before they reach kindergarten.

Eleven percent of our population is comprised of children between the ages of birth and eight, which is defined as early childhood by the National Association for the Education of Young Children (NAEYC). We know that about 64 percent of these children live in families where all parents work. Many more live in families where parents attend school to improve their job skills. This is why early care and education programs are in such high demand, and yet high quality choices remain limited despite Montana's best efforts to improve quality by using the research that tells us how to make the difference.

Many people enter the fields of early care and education with minimal qualifications, training and education, and yet we know that not just anyone can do the important job of meeting the needs of young children and families. Early childhood is the time when social, emotional, physical and cognitive development interplay to set the stage for future success. Early childhood programs and teachers become a front line of support for families as they navigate through the early years. Well-educated teachers and caregivers are in a position to identify strengths (and areas of concern) that appear early on. Well-qualified early care and education practitioners can help families make connections with the community resources available to support their children.

High quality early childhood education boosts children's language development, math ability, thinking and attention skills. The benefits can be tracked in kindergarten and beyond. In fact, long-term research shows that benefits can be tracked into adulthood where employment and home ownership are more likely and the risks of high school drop-out and arrests for violent crimes less so. It is also well documented that high quality programs can save taxpayers money by reducing costs of special education, rates of juvenile delinquency, adult incarceration and the need for public assistance. (*Investments in Early Childhood*, May 2008)

Early childhood is the time when social, emotional, physical and cognitive development interplay to set the stage for future success.

For more than ten years, the Early Childhood Project has coordinated early childhood workforce development by:

- Defining the knowledge, skills and dispositions essential to providing high quality early care and education for young children and families in the Montana Knowledge Base, a guide to professional practice.
- Honoring early childhood professionals who achieve levels of specialized training, education and professionalism through *The Practitioner Registry*, the *Career Path* (a framework of nine levels) and online *Professional Development Records* for directors, teachers, and support staff.
- Partnering with a broad stakeholder group to refine, upgrade and provide a rich continuum of training and education to meet the needs of practitioners at all levels of the *Career Path.*
- Providing incentives, awards and scholarships to those who rise to the challenges of increased levels of education and professionalism.
- Developing early learning guidelines for infants and toddlers and three- to five- year-olds in collaboration with many state partners.
- Sponsoring leadership development in the field for center-based early childhood directors and adult learning education for trainers.

Unfortunately, compensation issues impede attracting and retaining workers. The disturbing fact remains that most teachers working with children under age five earn much less, without benefits, than teachers with equivalent education in K-12 classrooms. This national crisis demands the attention and recognition of leaders and policymakers at all levels, and their commitment to move toward solid solutions.

The Early Childhood Project is proud to be part of a continually improving early childhood system. We welcome input from families, partners, early childhood practitioners, policy makers and others as we remain dedicated to best beginning for all young children and families in Montana.

—For more information, contact us at 1.800.213.6310, ecp@montana.edu or Libby Hancock at libbyh@montana.edu.

Great Early Childhood Resources

- *Montana Early Childhood Project: www.mtecp.org*
- *Montana Early Childhood Services: www.childcare.mt.gov*
- *Investments in Early Childhood: An essential industry that is both good for business and vital to Montana's Economy (May 2008)*
- *Montana Child Care Plus: www.ccplusplus.org*
- *National Association for the Education of Young Children: www.naeyc.org*
- *Center on Social Emotional Foundations for Early Learning: www.csefel.uiuc.edu*
- *Early childhood research: www.childcareresearch.org*

The Vicki Column

"Raising children is presented at first as a true-false test, then becomes multiple choice, until finally, far along, you realize that it is an endless essay . . . One child responds well to positive reinforcement, another can be managed only with a stern voice and a timeout. One boy is toilet trained at 3, his brother at 2. When my first child was born, parents were told to put baby to bed on his belly so that he would not choke on his own spit-up. By the time my last arrived, babies were put down on their backs because of research on sudden infant death syndrome. To a new parent this ever-shifting certainty is terrifying, and then soothing. Eventually you must learn to trust yourself. Eventually the research will follow."

—Anna Quindlen

Author Anna Quindlen has said that every part of raising children is humbling, and that in raising her children, she made mistakes . . . mistakes that have since become enshrined in the *Remember When Mom Did* Hall of Fame. But she says her biggest mistake was that she did not live enough in the moment.

"This is particularly clear now that the moment is gone, captured only in photographs. There is one picture of the three of them sitting in the grass on a quilt in the shadow of the swing set on a summer day, ages six, four and one. And I wish I could remember what we ate, and what we talked about, and how they sounded, and how they looked when they slept that night. I wish I had not been in such a hurry to get on to the next thing: dinner, bath, book, bed. I wish I had treasured the doing a little more and the getting it done a little less."

I think about that as I look at my boys, who are growing so quickly they seem to be in fast forward, blurring before my eyes. Looking at these big boys, I remember when they were so small that just getting them out the door meant *I* was in fast forward, that *my* life was a blur. I remember one day in particular. I got up early, planning to start the day with a good cup of coffee and the newspaper.

I started the coffee, thinking how great it smelled, felt the cool air on my skin as I walked out to grab the paper…poured the coffee… started to lift it to my mouth, then heard the baby cry. The early morning fast forwarded through feeding the baby, changing the baby, picking clothes for the toddler and cajoling him into eating (*Just a few bites!)*…finding socks and clothes and filling diaper bags for all concerned, all while answering the inevitable questions: *Where's my blankie? Why can't I watch cartoons for a few minutes? Why is the baby crying? Why can't I have cookies for breakfast?* And the worst: *I don't want to go to daycare, Mommie. Can't we just stay home?*

And then I noticed the coffee, stone cold. In passing, I stuffed it in the microwave and hit *start*. By necessity, getting dressed was last because I could never be sure the clothes would still be clean enough to wear if I left more than a few minutes between dressing and leaving. My last task that morning (and every morning for years) was checking the mirror to make sure I could walk into work without hearing snickers or seeing horrified stares. I grabbed the coffee (*cold again!),* dumped it in a cup over ice, added sugar and milk and called it iced coffee. Finally, the kids were buckled into car seats, their diaper bags crammed in next to them…and away we went. It was a whirlwind, a juggling act. It still is, though the patterns and needs (and the questions) have changed.

As we've put this issue of the *Prevention Connection* together, I've thought about the pressure we put on ourselves. As professionals, we know that we have to keep going or lose years on the career track, and yet, as parents, we know that our babies are at their most vulnerable, growing—in and out—so fast that their wiring almost crackles.

In the interim between then and now, I've learned not to expect perfection. I've learned that the most important things I can do are be patient with myself and present to them. Being present doesn't mean being attached at the hip, but it does mean stopping to take pleasure in the smell of the baby, the sight of the mop-headed toddle struggling to get socks on, the sounds and the feelings and the sights.

Children only get one childhood. They need clear expectations, rules and the boundaries to keep them safe within their world. But we, as parents, only get one chance, as well. One chance to be responsible and responsive . . . to live in the moment . . . to refrain from hurrying past, from blinking and missing it all. I look at my children and sometimes they seem to blur. And it is in that moment that I try to take the time to slow, to concentrate, to focus . . . grateful for this day, for this life and for these children.

Vicki

Notes from the Edge
Learning to Say Yes

—Sara Groves

The words I utter over the course of the day more than any others are: *no . . . stop . . . get down . . . get off of that . . . get out of there . . . stop . . . no . . . that's not safe . . . stop . . . I said stop . . . I told you no . . . and no!*

Some days, it seems all I do is find new ways to say *no* over and over again. *No*! is my rallying cry, my call to battle.

I am the mother of two very busy boys, boys who consistently amaze me with their ability to find unique ways to hurt themselves in their exceedingly child-proofed environment. They're not drinking drain cleaner, but Peter, my two year-old, does hurtle himself from one piece of furniture to another. And I can't begin to tell you how loudly I said *NO* when I found Mike, who is five, shooting down our hill, crammed into the bed of a Tonka dump truck.

Most of the time, I tell my children *no* to protect them from themselves and their complete lack of sense. But I also often say it completely out of habit.

For instance, when we visited the library the other day, Peter wanted to check out every *Curious George* book on the shelf. Every single one? Was he kidding? How much reading about an unsupervised monkey can a person take? *No way*. Mike often wants to make his own lunch. But he just turned five! *Make his own lunch?* He'd probably stab himself in the eye with a butter knife! *Forget it.*

When a friend of mine, who happens to be a child development expert, was visiting, I mentioned how there are days that all I do is say *no*. She listened and then made what might be the most preposterous suggestion I've ever heard: "Why don't you try saying *yes* more often?"

I wanted to take her by the shoulders and say, "Are you completely lost it, woman? Say *Yes???!* Why don't I just hand them matches and kerosene and leave them alone for the day?"

"If their health or safety is not in jeopardy, what's the harm?"

I could think of the harm in saying yes—*complete mutiny*. But I thought my friend, who has actually gone to school for this kind of thing, might know more than me, since I am learning about children in a trial-by-fire manner. So I decided to give saying *yes* a one-week trial.

The results: Peter wore the same too-small sweatshirt nearly every single day…in public. Mike ate a lot of mangled-looking PB&Js with enough jelly on each one to give him his fill of sugar for the week. We managed to avoid the *Curious George* collection at the library, but not the truck book collection. And we ate lunch an hour late one day because they were having too much fun sledding to stop.

All in all, not *exactly* mutiny. I still spent a lot of my day saying *no* since it has been proven that 99.99% of the time, two and five year-olds are not superstars in the logic department. When Peter hopped on the cat, holding the cat's ears as if they were reigns and shouted "Yee-haw," I had to step in. When Mike began ruminating about tying his new bike to his sled to test if he could go fast enough down our hill to blast into space, he heard a resounding, *No!*

But (and I really hate to admit this) saying *yes* worked. Nobody lost an eye and my kids did not take over my house and lock me in the basement. And, best of all, life was a little easier. There was significantly less whining and complaining, which resulted in significantly less stress for me. Could it be? Could saying "yes" instead of "no" make parenting easier?

Parenting is a funny job. Your objective is to shepherd your kids through childhood so that, as adults, they can manage without you. A big part of fulfilling that objective is learning when they ought to say no. Whether it's no to drugs, drunk driving, a bad date, an unfulfilling career, a loveless marriage—learning to say no at the right time is an important part of making good decisions.

Failure is part of learning. Trying is part of learning. And if kids aren't given the chance to try and fail, how do they learn?

As for me, I'm learning, too. Trying, failing, and learning—that *yes* is sometimes much more effective than no.

Bonding

It is in relational bonding that children learn to get their needs met, learn about the world and see themselves as successful communicators. Babies learn to trust by experiencing consistent and loving care. Bonding is the cornerstone of human development, influencing a child's cognitive, physical and social/emotional development. A baby who has become attached to a significant adult can form a strong conscience and go on to lasting relationships with others. Through bonding, children learn to regulate feelings and emotions. Brain architecture is influenced by bonding and attachment, as are the child's language abilities and entire central nervous system. Babies and parents need time together and time to be close and to fall in love with one another.

Sara Groves is the author of Momoirs, a weekly parenting column in the Helena Independent Record.

STARS to Quality

—Jamie Palagi

Rating systems are so commonly known in the hotel and restaurant industry, that we may all have some sense of the difference between a Four-Star restaurant and a Two-Star restaurant. Families in Montana will soon have a similar rating process to assist them in choosing high quality early childhood education for their children. Many states have implemented quality rating systems to recognize early childhood providers for their efforts in achieving quality and to provide parents with the information they need to choose high quality care and education for their children.

Over the course of the past two years, early childhood stakeholders have been developing their vision for quality early childhood in Montana and have identified a new approach to investing in (and ensuring) better outcomes for children and support for early childhood professionals as they pursue quality improvement. This resulted in the proposed *Best Beginnings STARS to Quality Program*, a voluntary Quality Rating Improvement System that aligns quality indicators with support and incentives for early childhood programs. The intent is to improve long-term outcomes for children, families and the professionals who work with them through quality early childhood experiences.

The Best Beginnings STARS to Quality system has three broad components:

1) *Quality Indicators or STARS*: STARS is a five star system, with Star One being licensed/registered plus a few additional requirements all the way up to Star Five, which equates with national accreditation.

   The components in the STARS to Quality system include: education, qualifications, and training for staff/caregivers; staff/caregivers to child ratio and group size; family and community partnerships; leadership and program management; and environments for care and learning. Each component has criteria in place that utilize rating scales, observations and evidence-based practices to validate the level of quality achieved. Program incentives and benefits are available to assist early childhood professionals reach quality improvement goals.

2) *Workforce Development*: Early childhood programs struggle to balance their budgets, and the early childhood industry continues to struggle to achieve professional recognition. Research indicates that early childhood professionals are most successful when they participate in professional development to understand child development and effective practices. We also know that professional development can be expensive and that the field of early childhood has high turnover. Through the STARS system, many avenues for professional development resources and support will become available for early childhood professionals, including merit pay and stipends to reward individuals for staying in and improving in their professional setting.

3) *Infrastructure*: The key to the STARS to Quality program is improvement. For programs that want to set quality goals and improve their program practices, resources and supports (e.g., technical assistance, training), tool kits and rating professionals are needed. Through the support of local and statewide resources, early childhood providers can achieve their quality goals by setting improvement plans, making programmatic changes, and improving staff qualifications.

The early childhood community has embraced the proposed *STARS to Quality System*, which is slated to field test in the summer of 2010. Participation will be limited by available funding, but we recognize the importance of expanding this program to meet the needs of the programs serving young children and their families, and ensuring that families have access to high quality, early childhood education.

—Jamie Palagi is the Early Childhood Services Bureau Chief of the Montanan Department of Public Health and Human Services. She can be reached at jpalagi@mt.gov or by calling 406-444-1828.

Great Resources: *The Early Childhood Services Bureau*

Montana's Early Childhood Services Bureau is dedicated to helping children and families succeed by increasing the affordability, accessibility and quality of early care and education.

The Early Childhood Services Bureau has an exceptional website that provides resources for early childhood professionals and families. Some of the links from this robust site include:

*— **Best Beginnings Childcare Scholarships** helps working families who qualify to find and afford high quality child care.*

*— **Best Beginnings Quality Programs** promote children's learning by improving the quality of Montana's early care and education and after school programs.*

*— **Best Beginnings STARS to Quality** a continuous quality improvement program for early childhood education in Montana.*

*— **Child and Adult Care Food Program** provides funding for nutritious meals and snacks while children are in child care.*

*— **Head Start - State Collaboration Office** effort links Head Start programs and communities through collaborative relationships.*

*— **School Readiness** provides information about how young children develop and how parents and professionals can best support early learning.*

*— **Find Childcare***

For more information, go to www.dphhs.mt.gov/hrd/childcare/

Emotional Development *. . . and School Success*

Children's early learning and development is multidimensional, complex, and influenced by individual, cultural, and contextual variations. Any discussion of school readiness must consider at least three critical factors:

1. The diversity (and inequity) of the child's early life experiences;
2. The wide variation in young children's development and learning; and
3. The degree to which a school's expectations of children entering kindergarten are reasonable, appropriate, and supportive of individual differences.

Children are not innately ready for school, but many factors contribute to a child's success. The National Education Goals Panel identified five important areas for school readiness including children's health and physical well being, social and emotional well-being, approaches to learning, language development, and general knowledge about the world around them. In addition, readiness depends on the expectations schools and kindergartens have of children.

Traditionally, the term *school readiness* was based on the assumption of a predetermined set of capabilities that all children needed before entering school, and yet the same child—with the same strengths and needs—can be considered *ready* at one school and *not* at another. Making sure that schools are ready for children is as important as having children ready for school.

The use of readiness criteria for determining school entry or placement can seem to blame children for their lack of opportunity and may be based on inappropriate expectations of abilities, failing to recognize individual variation in the rate and nature of individual development and learning. Making sure that children enter school ready to succeed is not just the parent's job. Almost one in five of Montana's preschool children lived in poverty in 2006, and almost 2/3 (52%) had working parents (Montana's Child Care Profile*). For children to enter school ready to succeed, all families with young children must have access to living wage jobs, decent health care and adequate shelter.

Everyone wants young children to enter kindergarten ready to succeed. Often the focus is on cognitive skills, early literacy or early math, but it is equally important to pay attention to the social and emotional skills that young children develop in their earliest years. These skills—how children manage their feelings, follow directions, concentrate, relate to others and approach learning—will enable them to succeed as they transition to kindergarten and first grade.

The importance of young children's emotional development for school readiness cannot be overestimated. Children who are emotionally well-adjusted have a significantly greater chance of early school success; children who experience serious emotional difficulty face an increased risk of early school failure. Children's ability to label and manage different emotions provides them with powerful social tools: using words, children can *talk through* rather than act out negative feelings. Preschool and child care settings offer a valuable opportunity to implement comprehensive, multi-pronged interventions that support young children's emotional and behavioral adjustment. Improvements in family income, neighborhood safety, and residential stability may have important and significant effects on children's emotional and behavioral well-being.

A report on school readiness from the National Center for Children in Poverty (2002) states: *Children's school readiness, their cognitive and social-emotional development, physical health, and eagerness to learn are built on a foundation of good parenting, economically secure families, and early childhood settings that promote children's learning.*

Research suggests that aiming primarily at academic and cognitive development of three-to five year olds is too narrow a focus. Children come from a variety of family backgrounds and experiences during their early years. Without attention to family economic security, nurturing early relationships, child care subsidy policies that promote healthy development, early childhood mental health interventions and meaningful indicators that track state and community commitments to children, promoting true readiness for school will remain elusive.

Sources:

— School Readiness Talking Points prepared by Billie Warford (March 16, 2003).

— Montana's Child Care Profile: http://nccic.acf.hhs.gov/statedata/statepro/display.cfm?state=Montana.

— Resources to Promote Social and Emotional Health and School Readiness in Young Children and Families: A Community Guide. Jane Knitzer and Jill Lefkowitz. National Center for Children in Poverty. http://www.nccp.org/publications/pub_648.html

Early Childhood and Homelessness

Children make up approximately half of the U.S. homeless population. An estimated 650,000 children under age 6 are homeless, representing nearly half (42 percent) of all homeless children. Homeless families (typically women with two children under age 5) face immense challenges in sustaining children's routines, including daily school attendance. Moreover, children without housing or who are in temporary housing situations face severe barriers to physical and mental wellness. Consistent child care and early education arrangements can provide a secure environment for young children experiencing homelessness. Yet, less than 16 percent of eligible homeless children are enrolled in early education programs.

During the annual 2008 Survey of the Homeless in Montana, 167 members of homeless families together identified 296 homeless children under age 5. Most were staying with family or friends, or living in transitional housing facilities, but 63 members of homeless families with very young children were staying in emergency shelters, 25 were staying outside, and 32 were staying in a hotel or motel.

Sources:
—http://childcareandearlyed.clasp.org/2009/04/help-for-homeless-children.html and—Montana Council on Homelessness www.mtcoh.org.

Ready 2 Read

—Sara Groves

The Montana State Library is pleased to announce the launch of its statewide early literacy initiative, *Ready 2 Read!* The campaign targets parents and caregivers of children aged birth to five and works to help parents understand the importance of sharing reading material and language with children from the time they are born.

Young children need a variety of skills to become successful readers. Reading experts have determined that six specific early literacy skills become the building blocks for later reading and writing. Research indicates that children who enter school with more of these skills are better able to benefit from the reading instruction they receive there.

Children prepare to read long before they enter school—early literacy is everything children know about reading and writing before they can actually read or write. Early literacy is a baby who chews on a book, a toddler who wants his favorite book read over and over, and a preschooler who "reads" a story to someone from memory.

"Every parent wants the best for their child, but not every parent is sure of how to accomplish that," said Darlene Staffeldt, Montana State Librarian. "The *Ready 2 Read* Campaign will work to increase awareness of the importance of sharing reading material and language with children—from the time they are born."

The State Library has launched a web site broken down by age group. Parents and caregivers can use the site to find activities that help develop early literacy skills, as well as age-appropriate reading lists, songs and fingerplays, as well as general information on early literacy and sharing reading and language with their children. Soon to come on-line at site will be videos that demonstrate best practices and that can be used as a guide by parents and caregivers with low or no literacy skills themselves. "We want every parent in Montana to understand that they have the skills to help their child succeed, regardless of their own literacy level," says Staffeldt.

The State Library has spent the past several years training librarians in early literacy best practices—from how to develop "books and babies" programs at the library to the latest information in infant neurological development. Training is scheduled to continue on a one-on-one basis and in group settings at conferences and online.

The State Library has worked to develop partnerships that will help libraries expand their reach beyond library walls. Through statewide partnerships with Women, Infant, and Children (WIC) programs, Head Starts, and county health departments, the State Library hopes to get information into the hands of parents and caregivers who may not already use the library.

"We are working closely with the Department of Public Health and Human Services and the Office of Public Instruction to share information with Montanans who are not necessarily aware of the many resources their local public library offers," said Staffeldt.

Plans for the *Ready 2 Read* initiative include additional partnerships, the development of television, radio, and print ads, and the development of informational brochures that will be distributed everywhere from libraries to pediatrician's offices to WIC offices and Head Starts throughout Montana. Training for librarians with the latest information on early literacy and childhood development will also continue. The State Library will provide all public and tribal libraries with a set of books and informational materials for the youngest readers. These projects will be completed as funding allows.

"Parents can help their child get *Ready 2 Read* with help from their local library," said Staffeldt. "Montana's librarians can show you how to nurture your child's literacy skills, long before he or she is enrolled in school. It's never too early to start. Let a Montana librarian help!"

—The State Library has launched a web site for parents at: http://ready2read montana.org. The Montana State Library website is also bursting with information (http://msl.mt.gov). For more information, call Sara Groves, Montana State Library Communications and Marketing Coordinator 406.444.5357 or SGroves@mt.gov.

Reading Readiness

Nationally, 46 percent of kindergarten teachers report at least half of their pupils have specific problems with entry into kindergarten, including lack of academic skills, difficulty following directions, disorganized home environments and problems working independently.

A significant number of children struggle with reading readiness and literacy skills. Children who start school behind, typically stay behind. They are at substantial risk for academic difficulties. The story begins well before school entry. Children's experience with books plays an important role. Many children enter school with thousands of hours of experience with books. Their homes contain hundreds of picture books. They see their parents and brothers and sisters reading for pleasure. Other children enter school with almost no time of shared book reading. There are few, if any, children's books in their homes. Parents, friends, brothers and sisters aren't readers.

Preschoolers need food, shelter, love; they also need the nourishment of books. Several studies point to a relationship between shared reading (adults and children looking at books together) and the emotional development of young children. The age at which shared reading begins is a strong predictor of young children's language abilities. The age at which parents start to read to their child is associated with their child's interest in and enjoyment of reading activities.

Source: Overview of Early Childhood Literacy: Colorado State Library. www.cde.state.co.us/cdelib/download/pdf/OverviewEarlyLitIssue.pdf

We would like for every parent in Montana to understand that the more they share language and reading materials with their children, the better chance their child has to succeed in life.
—Darlene Staffeldt

The Preschool Years

—Sandra J. Bailey, Ph.D., CFLE

The preschool years are an exciting time for parents. Between the ages of three and five, the child grows more independent, and each day brings exciting new discoveries. She is curious about the world around her and will often ask "why." Your preschooler can help around the house with simple tasks such as picking up her toys or making her bed. Helping her learn to do these tasks provides a base for learning more complex skills and teaches her about being a member of the family.

Physically, your child's growth has slowed. Because of this, her appetite may not be what it was and she may become a picky eater. Her large motor skills, such as running and jumping, have become more coordinated. She is beginning to refine small motor skills such as holding a pencil and trying to write.

Children's play changes as they move from being a toddler to a preschooler. The preschooler begins to engage in make-believe play. Where before she would only use a cup to pretend to drink something, now she may use it as a scoop or a hat, pretending it is something else. She is more social in her play and likes to interact with others rather than playing alongside friends. At the same time, preschoolers are very egocentric. In their eyes, the world revolves around them. It is difficult for them to understand the views of others. Although preschoolers are learning to share, disagreements can erupt if she *really* wants a certain toy.

Preschoolers are anxious to learn. Although they are curious and want to try new things, they can also become easily frustrated if they are not successful. Parents can help as they learn new skills. For example, if your preschooler wants to try to pour her own juice, try putting some in a smaller pitcher for her to pour or assist as she pours from the larger container. If spilling occurs, use this as a teachable moment and help her learn how to clean up the spill. Encourage her to try again.

At this age children are building a base of information about their world. Preschoolers are interested in grouping things (e.g., blocks of the same color), but are unable to understand the concept of conservation. For example, if you place eight ounces of water in two glasses, then pour one of the glasses of water into a bowl, the preschooler cannot see that there is still the same amount of water in each container. She is likely to say that the glass has more water than the bowl. Another example would be to place two rows of five pennies each on a table. Next, place another two rows of five pennies next to it, but stretch out the spacing on this set. Most will say that the longer line of pennies has more, even though both include the same number of coins.

Parents are truly a child's first teachers, and there are many things parents can do to assist in development:

— Provide nutritious meals in small portions. Do not be concerned about picky eating. Simply continue to offer a well-balanced diet.

— Have a set routine so that she knows what to expect. This will help in handling transitions. Although preschoolers cannot tell time, they know what to expect from the schedule at the day care center.

— Develop a consistent bedtime. This helps avoid battles. Have a routine such as reading a story before bedtime to help your preschooler relax.

— Encourage your preschooler to help around the house. Teach her how to make her bed and fold clothes, but do not expect perfection.

— Encourage pre-reading skills by having books in the home. Take your preschooler to the library and check out books.

— Have art supplies (such as crayons and paper) available. Encourage your preschooler's creativity.

— Take your preschooler to local parks, grocery shopping, museums, and appropriate public events. She will soak up knowledge from these experiences.

— Remember that it is the quality time that you spend with your preschooler that she needs the most.

—Sandra J. Bailey, Ph.D., CFLE, is an Associate Professor and Extension Specialist at Montana State University, Bozeman. She can be reached at baileys@montana.edu or 406.994.6745.

Great Resources

www.extension.org is a new national website for the USDA Extension Service. The Just in Time Parenting page has newsletters relating to young children. The Family Caregiving page has articles and information for grandparents raising grandchildren.

www.cyfernet.org is the Children Youth and Family Extension Research Network that has information on children and families.

www.msuextension.org is the site of Montana State University Extension. There is a variety of information including online fact sheets on parenting, family interaction, nutrition, and family finance.

Preparing for Kindergarten

—Research has shown that the sheer number of words that babies hear is critically important for their language development. Every word counts. —Dr. Lucy Hart Paulson

Preparation for kindergarten happens long before the first day of school. It's a journey that the family and child prepare for from the very beginning. To be successful, a child needs to develop a wide range of skills: social/emotional (such as the ability to express needs, recognize feelings and interact with others), physical skills (like being able to hold a pencil, use scissors, sit at a desk or table), and cognitive skills (like recognizing some of letters in his/her name).

Dr. Lucy Hart Paulson, a speech and language pathologist and literacy specialist at the University of Montana, encourages families to develop language skills from birth. "Research has shown that the sheer number of words that babies hear is critically important for their language development. Every word counts." This means talking, talking, talking with your baby: the more words they hear, the better. Talk about your day, what you are doing, what you see . . . and offer the chance to respond. Their cooing followed by your encouraging response, "You don't say?" engages them in more conversation, thus more words.

Furthermore, Paulson warns about using "educational" DVDs and television with your infant. Very often, these DVD's are promoted as tools to help promote child development. A 2007 study by Frederick Zimmerman shows that the *overuse* of baby DVDs and videos actually may slow infants 8 to 16 months of age down when it comes to acquiring vocabulary. For every hour per day spent watching baby DVDs and videos, infants understood an average of 6 to 8 fewer words than those who did not watch. These findings have led the American Academy of Pediatrics to recommend that children under age two have little to no screen time (e.g., televisions, computers or video games).

As the baby becomes a toddler or a preschooler, Paulson recommends that parents help by playing with words, using rhymes and focusing on the syllables and sounds in words. This helps build a foundation for later understanding of how words work in reading and writing. Finger plays like the itsy-bitsy spider or tongue twisters, in which all the words start with the same sound, are easy and meaningful.

While language and other cognitive skills are important, social/emotional skills are also crucial to a child's success in school. A 2003 survey of Missoula County Public Schools kindergarten teachers found that attention skills such as listening to a story for ten minutes or working on task for fifteen minutes were a challenge for as many as one-third of new kindergartners.

In today's classroom, children work collaboratively on assignments (which is a social/emotional skill in and of itself) as well as on their own. Again, the research on television viewing by young children is important to consider. Studies show that for each additional hour of television very young children watch (on average) before age three, correlated with a ten percent greater likelihood of having attentional problems (Christakis, 2004).

One way that families can help children develop a good attention span is by building quiet time into the daily routine. Such activites might include having the child work on a project such as coloring, playing with colored shapes, cutting pictures from magazines and gluing them on to paper, playing with blocks or looking at books. The goal is to have the child "working" or learning independently, focused on one project for at least ten to fifteen minutes at a time.

Reading to a child every day not only helps develop the attention span and language development, but can also support social/emotional development. Laura Pickett, an Early Learning Parent Educator at WORD recommends reading books about starting kindergarten with the child. A good example is Nancy Carlson's, *Look out Kindergarten Here I Come.* Laura states, "Books provide an opportunity to talk about what to expect in kindergarten. The child can relate to the characters and identify their feelings—whether it's excitement or fear, about starting school." Talking about what kindergarten will be like can help allay fears of the unknown and allow for an opportunity to discuss feelings about going to school. Very often, it's good for the parent to identify and address his/her feelings about the change so that s/he can be positive when talking to the child. The parent's tone helps set the stage.

Play can be one of the most important things that a child can do to prepare for kindergarten. Playing with others helps develop problem solving and collaboration skills. Activities in which children have to pick up and manipulate objects (such as beads or clay) get their fingers ready to write. Running, jumping and climbing not only keeps them healthy, but develops body control and coordination, which in turn gives them the strength needed to sit up straight so they can work at a desk.

The seemingly little things that a parent does every day (like playing outside, singing, sorting laundry, cooking together, talking around the dinner table) are all the things that support the child's learning. Parents and caregivers are the child's first and most important teachers. The parent *is* the expert when it comes to his/her child. It's important to talk with the child's teacher, to share the child's interests, likes and dislikes. The school is a partner in the child's learning, and in partnership with parents, it is possible to ensure that the child is happy, safe, learning and growing.

This article was gratefully adapted from the *Missoulian's Health Page*, which features a monthly column by the Healthy Start Council of the Missoula Forum for Children and Youth, a coalition of groups and individuals working collaboratively to help Missoula's kids grow up to be healthy and resilient.

WORD, Inc.—Women's Opportunity & Resource Development, Inc. (WORD, Inc.) is a member of the Healthy Start Council that creates opportunities, programs and policies that inspire and support women's development, leadership and choice, for the benefit of our entire community. For more information, visit www.wordinc.org.

Inclusion in Early Childhood Settings

—Sandra Morris

A lot has changed in the last thirty years when it comes to the inclusion of young children with disabilities and developmental delays. Teachers and parents alike have seen the positive impact inclusion has on very young children. Children thrive when their severe delays do not prevent them from having the opportunity to play with other children. There are also reciprocal benefits for children who do not have disabilities when they observe and interact with children who do.

Children with disabilities are included in early childhood programs because the benefits are greater than the challenges. This is not to say that inclusion is easy, that everyone values inclusion in the same way or that we have nothing more to learn. It *does* mean that people have begun to recognize the importance of inclusion and to make sure their values are reflected in public policy and practice.

Early childhood professionals who have practiced inclusion would be the first to admit that there is always more to learn. In a sense, inclusion is the result of an evolving philosophy that grows and changes as knowledge, experience and understanding of children with disabilities and their families grow and change.

At some point in the discussion about inclusion, it becomes necessary to move away from general statements, identify what inclusion looks like in practice, and compare that picture with what happens in a neighborhood early childhood program. In making this comparison, there are two points to remember: 1) it *looks* the same, and 2) it *is* the same. Best practice for young children is best practice, regardless of the abilities of the children enrolled.

Inclusion does not change the nature of the program itself. Inclusion simply means that teachers have created a nurturing, responsive environment where children's individual needs, regardless of whether or not they have a disability, are met through appropriate practices and high quality care and education. Children with disabilities enjoy the routines and activities basic to these programs, not because routines and activities are specialized for their disability, but because they are specialized for *each child*.

Past experience may make people think that children with disabilities require one-on-one care and education. Since this is often impossible in early childhood settings, one solution may be employing a full-time aide for the child with a disability. However, a qualified aide is not only expensive, but can set the child apart and/or hinder the child's opportunities to play and interact. Because it is so important that a child with a disability get the full benefit of interacting with other children, it is important to explore many alternatives to meet needs in the child care setting.

Sometimes all that is really needed to make inclusion work is another pair of hands, especially at certain times of the day. This person does not replace the teacher, but provides support through necessary, but not always child-related, activities. Extra hands can make snack or lunch and clean up afterward, prepare the art area and arrange the products on a shelf or wall, or prepare a mailing to parents. Providing this kind of support does not require particular training or experience with young children and can be done by individuals who are retired, students, parent volunteers or adults with disabilities. This type of assistance frees teachers to do what they do best: observing children's engagement with one another and with play materials, providing support for individual children during play and routines, making instant and planning future modifications.

Inclusion becomes possible when early childhood professionals develop and articulate their personal beliefs and attitudes about inclusion as part of their overall philosophy of working with young children. Their philosophy guides what they do on a daily basis and is reflected in the kinds of toys they provide, the way they talk with and about children, and how they talk with parents.

In the near future, it will no longer be necessary to define "inclusion" or use it to describe this or that early childhood practice. On that future day, quality early childhood practice will be inclusive of every child by definition.

—Sandra L. Morris is the Montana Inclusion Outreach Coordinator for the Child Care Plus+ Center on Inclusion in Early Childhood of the University of Montana's Rural Institute. For more information, visit www.ccplus.org or call 1-800-235-4122.

Red Flags for Autism Spectrum Disorders

Impairment in social interaction

- *Lack of appropriate eye gaze*
- *Lack of warm, joyful expressions*
- *Lack of sharing interest or enjoyment*
- *Lack of response to name*

Impairment in communication

- *Lack of showing gestures*
- *Lack of coordination of nonverbal communication*
- *Unusual prosody (little variation in pitch, odd intonation, irregular rhythm, unusual voice quality)*

Repetitive behavior/restricted interests

- *Repetitive movements with objects*
- *Repetitive movements or posturing of body, arms, hands, or fingers*
- *1 in 150 children are born with autism (2002)*

Autism data

- *1.5 million Americans are affected by autism*
- *10-17% increase in incidents of autism each year*
- *$3.2 million per capita cost of autism over the person's lifetime without effective intervention*
- *47% of children can be mainstreamed as a result of intensive Applied Behavior Analysis programs*
- *$1.7 million to $2.8 million per person estimated cost benefits (avoidance) from intervention*

Source: www.dphhs.mt.gov/dds/ddp/autism.shtml

Public Health Home Visiting

—Jo Ann Dotson

Home visiting is a service delivery method that can improve birth outcomes, reduce the incidence of premature and low birth weight births, child abuse and parental substance use. It can also enhance the motor and/or cognitive development of infants, promote more effective health services utilization, improve the quality of social supports, as well as maternal and child physical and mental health. In the mid 1980s, a home visiting program targeting high-risk pregnant women and their infants was piloted in four Montana counties. The pilot program operated on the assumption that early entry into prenatal care would result in improved pregnancy outcomes. Public health nurses in these communities developed agreements with local primary care providers who agreed to accept, as patients, pregnant women who had no resources. Nurses contacted women in their homes, and the service, initially intended to be a single home visit to arrange for prenatal care, became a series of visits through which the nurse assisted the family to access care, understand and participate in their plan of care, and to receive other assistance and education. Those pilot programs lead to the development of legislation passed by the Legislature into law in 1989: *Montana's Initiative for the Abatement of Mortality in Infants* (MIAMI). The purpose of the MIAMI project was to:

- ensure that mothers and children received access to quality maternal health services,
- reduce infant mortality and the number of low birth weight babies (5 pounds or less), and
- prevent the incidence of children born with chronic illnesses, birth defects, or severe disabilities due to inadequate prenatal care.

The MIAMI Program charged the state Department of Health with developing community-specific access to prenatal care, risk assessment and client education. The program was renamed *Public Health Home Visiting* in contract language in the early 2000s to more clearly describe the purpose.

Montana's home visiting program originally targeted (and continues to focus on) high-risk pregnant women and their infants. Unlike the Nurse/Family Partnership, a home visiting program developed by David Olds and colleagues that targets first-time, primarily young mothers, the Montana program serves all at-risk women, regardless of maternal age, parity or income. In 2008, home visiting services were provided in 17 Montana communities, including three tribal communities. Home visits are provided by a team of public health professionals, who, in 2006, had provided services to about 1,200 pregnant women and 900 infants statewide.

Home visiting teams include a public health nurse, a social worker and a dietician. This model was adapted from Washington State's *First Step Program*. In the 1990s, local contractors opted to add a para-professional to the home visiting team. Para-professionals provide enhanced home visiting services to women at risk for alcohol and illicit drug use. Home visiting programs provide services as early as possible during the pregnancy, and continue to work with families through the infant's first birthday.

Since 2000, Montana's home visiting program has been supported with state general funds. At the local level, contractors support the program with local public health dollars (mill levies), billing revenue from Medicaid targeted case management, and in some communities, with federal Materian and Child Health Bureau grant funds distributed to counties.

Pregnancy outcomes are important to society and to the health of the public. Home visiting programs have the potential to address risk factors that negatively impact pregnancy and infant development. Risk factors such as stress, nutrition, and substance use can be mitigated by consistent and supportive intervention by health professionals. All in all, this is a top notch prevention strategy that provides one of the most important gifts of all: a healthy start.

—Jo Ann Dotson is the Chief of the Family and Community Health Bureau. She can be reached at 406.444.4743 or jdotson@mt.gov.

Benfits of Home Visiting

Women who receive home visiting services are more likely to be young, have less than a high school education, be unmarried and use tobacco and alcohol than women who do not receive home visiting services in Montana

In 2006, women who received home visiting services had fewer low birth weight births (7.3%) than similarly at risk women who did not receive home visiting services (7.9%).

Women who received home visiting services also had significantly more prenatal visits (mean of 11.45) compared to women who did not receive home visiting services (mean = 10.64)

—Dotson, 2009

Becoming the Best *Me* I Can

—Tera

I am a 28 year old mother of three incarcerated at the Montana Women's Prison (MWP). I have a daughter who is 11 and sons who are 10 and 8. Their father and I have been divorced and both reside in Billings. We both have very supportive families that make it a priority that my children and I keep and maintain a close quality bond. The *Supporting Kids of Incarcerated Parents Program* (SKIP) stands for that very thing. I am able to have my children come for a couple of hours in the evening. Those nights, I have the opportunity to cook a dinner with my kids. They can bring homework or anything else they choose to bring to share with me.

When the visits first started, I had an initial visit with their current primary caregivers (their father and grandmother) to establish goals and plans for successful visits. My children were given the option to either have visits that included all three of them or individual visits to allow them special quality time. They decided they would prefer the individual visits. They have been so beneficial. I get personal time that is just theirs, where we plan our meals and activities together. Aside from the special kid visits, my children also come to all kids' days and weekend visits, when we can also spend time as a family together.

Before the one-on-one kid visits, my children struggled with competing for my attention and having to share it. At times it made the visits stressful and left everyone feeling upset. Since then, they have gotten the special time and attention individually that they need. They don't compete during the family visits, so we get some quality family time as well.

The Family Tree, which collaboates with MWP to provide the parenting program, will remain a support group when I leave here. They are a beneficial part of reunification with my children and me. They take value in family and place great importance on healthy families. I have also joined several parenting groups appropriate for the ages of my kids. I'm not only given support, I'm given the knowledge I need to be a healthy, informed parent. The privilege of the visits comes with obligations that I need to meet as well. Included in those are parenting classes and participation, volunteered services to the parenting program, parent group meetings and an exemplary institutional conduct status. It not only is a great benefit to my children, it gives me positive ways to spend my time. I can focus on my priorities and consume myself with what is important…and that is bettering myself and becoming the best me I can, to be healthy for my children and our family.

This program gives us the encouragement and hope we need to deal with this separation. We together accept and deal with the negatives, but build off the positives. Parenting should be an honor, not a right, and I'm going to take this opportunity to gain the most out of it I can. This program also has connections to outside resources that work directly with our children—school counselors, child development specialists, family therapy and programs that allow our children to gain and give support to other children of incarcerated parents. We are given plenty of resources—it's a matter of being proactive and doing something positive with a negative situation.

As unfortunate as my current circumstance is, I'm very fortunate to receive all this knowledge and information that may not have been available otherwise. My sincere gratitude to the program facilitator and all her hard work to make this happen and to all those who support this great program.

MWP

Montana Women's Prison in Billings houses approximately 265 adult female offenders and has partial responsibility for 245 more. More than 90 percent of inmates at MWP are involved in educational or vocational programs and nearly all participate in a parenting program where they can learn prenatal skills, infant care, adolescent behavior and more.

In 2007, the prison initiated a therapeutic community model in all housing units. A therapeutic community is a drug-free environment in which people with addiction and criminal or antisocial behavior live together in an organized and structured way that promotes change and makes a drug-free life in society possible. The therapeutic community forms a miniature society in which residents and staff fulfill distinct roles and adhere to clear rules, all designed to promote "right living" behaviors.

More than 30 organizations provide assistance with such events as religious activities, pet therapy, tutoring, public speaking training, and arts and crafts activities. The prison continues to expand its vocational and education programs to meet the needs of women offenders.

For more information, visit www.cor.mt.gov/mwp/default.mcpx or see the 2009 Biennial Report at www.cor.mt.gov/content/Resources/Reports/2009BiennialReport.pdf.

Strong Connections

—Julie Gauthier

Just up the hall from the front entrance to the Montana State Women's Prison (MWP), you will find the *Parenting Module*. This area, complete with a kitchen, living room, bathroom, office and outside yard, is where many women interact with family members, face-to-face or over the telephone. The MWP Parenting Program originated more than twelve years ago—literally out of a cardboard box. The facilitators at the time would haul supplies into the cafeteria and set up a makeshift classroom. For the next five years, the program grew slowly out of the box and into the existing module.

August will mark the fourth year The Family Tree Center (FTC) in Billings has collaborated with the MWP to provide the parenting program at the prison. This not-for-profit family advocacy agency contracts to provide services that had already been established, and grows the program in the areas of community and family connections. The Family Tree Center (FTC) provides several parenting classes, support/education groups for pregnant women who will give birth during incarceration, support groups for grandmothers, and community outreach through education and presentations. Most importantly, FTC spends much of its time and many of its resources on strengthening the connections between mothers, children and the children's caregivers. This area of service is a top priority and includes many options designed to maximize the impact for all involved.

When the child desires contact and everyone involved is supportive, many efforts go into establishing the contact. The first step to opening the door of communication is a letter from the incarcerated mother to the caregiver. This letter informs the caregiver of the *Supporting Kids of Incarcerated Parents Program* (SKIP) through FTC. SKIP Coordinator, Vicki Ingraham, advocates for the caregivers and is the first person many open up to. The letter includes a list of SKIP services as well as Vicki's business card. The caregivers are encouraged to call Vicki to establish the level of communication they would like to see on behalf of the child(ren). Vicki also visits with them extensively about the stressors they face and the ways in which she may be able to support them.

Financial support seems to be the biggest need expressed by caregivers. Fuel costs, hotel, food and phone charges are the largest burdens in maintaining a relationship with the incarcerated mother. The SKIP Program currently assists with some of these costs, making visitations more likely.

MWP Parenting offers a monthly *Kid's Day* event on the third Saturday of each month, when kids are welcomed to the facility for a two-hour period. During this event, the regular visiting area is transformed into a more "kid-friendly" environment with crafts, toys, games, snacks and books. The children are dropped off at the facility and remain under the care of FTC staff members who make their needs and enjoyment the top priority.

Caregivers are encouraged to stop by The Family Tree Center (located just two blocks north of MWP) before Kid's Day gets underway. Vicki provides lunch, assistance for fuel and hotel costs, and an opportunity to visit with other caregivers who may be experiencing the same types of stressors. Past participants have contacted FTC after a family member was released from MWP to thank the agency for being there to listen. They often express gratitude for providing an outlet to share where there had never been one. Children have also expressed gratitude for the friendships made with other children going through the same experience.

The Parenting Module was built with weekly one-on-one visits in mind. Unfortunately, due to numerous barriers (see side bar), consistent opportunities for connections are available for just a few families. There are many requirements that have to be met before the visits can be established.

1. Because the children are the first priority, they must express that they *want* the visits. On rare occasions, the mother and/or caregiver has determined it should be an obligation for the child; therefore, a face-to-face meeting is always held first to establish children's feelings about potential contact.

Continued on Page 15

Barriers to Connections

A large proportion of the women at the Montana Women's Prison are mothers, but the level of contact with their children varies greatly. The number of women who have regular contact is actually very small due to several factors, most commonly:

1. loss of parental rights;

2. distance of children from the facility;

3. fractured relationships between mothers and the caregivers and/or the children;

4. hesitance on behalf of caregivers to expose children to phone/physical contact when trust has been betrayed numerous times;

5. unstable parental mental health; or

6. professional recommendations that contact would not be beneficial to the child's mental health.

Strong Connections

Continued from Page 14

2. The mother must be enrolled in parenting classes that continue as long as the visits take place.
3. The mother must plan an activity and a meal that she can prepare with her child(ren).
4. Mothers attend a weekly discussion group. This group is designed to encourage mothers to talk about the ups and downs of trying to be an involved parent from prison. The time is also used for cleaning and menu planning. The one-on-one visits usually last between two and three hours. Multiple visits during the week would be more beneficial, especially for infants and toddlers, but time constraints prevent this. During supervised visits, the mothers follow a routine that includes cooking and eating a meal together, play time, art projects, homework, cleanup and reading/connection time.

The program recently opened time slots for consistent, scheduled phone contact. Again, *if* the child wants the contact and the caregiver supports the calls, the mother has the opportunity to phone the child(ren) once a week for ten minutes. Mothers have to be involved in on-going parenting classes and must adjust their schedules to accommodate those of caregivers. These calls may be the only opportunity for phone contact, as, generally, incarcerated women must call collect. This puts such an enormous financial burden on caregivers that many have been forced to block their phone lines to avoid the high-priced calls. Calls through the Parenting Program have no financial impact on caregivers, thereby decreasing another stressor.

FTC staff strives to make a three-fold impact. In keeping with the mission of the agency, the ultimate goal is *healthy children*. Strengthening family bonds is the first step toward creating healthier children. By supporting caregivers, the staff hopes to decrease stressors and thus help ensure healthier homes and family members. The final goal is reduced recidivism. National research suggests that providing opportunities for stronger, healthier connections decrease recidivism by as much as six times, so society benefits as well. The cycle of dysfunction is relentless and it takes a great deal to break it. Regular, healthy opportunities for connections provide some of the most important tools for breaking this cycle and strengthening the family as a whole.

—If you would like more information on the MWP Parenting Program, please contact us at: MWP Parenting Program 406.247.5146 or jgauthier@mt.gov.

A Work in Progress

—Alexandria

I've been involved with the Family Tree Center's Parenting Program now for about three years. My daughter, who's two, comes weekly for one-on-one parent-child visits that we both look forward to. My daughter was born in the time period that I was incarcerated. My parental bond has been strengthened by our weekly visits. I've been blessed with the chance to be able to interact closely with my baby as she grows up by spending two to three hours a week of quality time just drinking her little personality in. I get the chance to feed her a snack, we cuddle and read books (which we both love to do). We do special art projects. She especially loves to play with the glitter and to finger paint. We learn shapes and colors by coloring with the crayons and the markers. We even let her use the markers on momma's arm, and we wash momma's arm off for the rest of the art project. That way she gets an understanding of how colors mix and how to make the color disappear. It also gives her a sense of being a "grown-up girl" because she gets to clean up her artwork.

Usually after art, it's playtime for my daughter and I get our dinner ready. Our meals are healthy and I try to make them kid friendly, but I happen to have a picky eater who says, "Me don't like it!" But we continue to try different things to learn what exactly she likes and doesn't like. We know she loves to eat just about anything with cheese. She also likes to eat raisins. We are trying to potty train her, so as a reward for using the "big potty" she receives a little cup full of raisins. Sometimes we don't make it, so it's a work in progress.

I wouldn't be spending these precious moments with my daughter if it wasn't for the MWP Parenting Program. I'm actually able to parent my child behind prison walls. I'm also getting educated on how to interact appropriately with her at her age level. I'd learned *Love and Logic* techniques in Elkhorn, but this parenting program enables me to use the skills, which makes parenting a lot easier for me and for her. Part of my parenting is my devotion to my class work. I want to learn as much as possible so that I can be a stable dependable mother for my daughter and one day we can be reunited.

If you have made mistakes, even serious ones, there is always another chance for you. What we call failure is not the falling down but the staying down.

— Mary Pickford

CCR&Rs: *Providing the Bridge*

—Anne Carpenter

The Department of Public Health & Human Services Early Childhood Services Bureau (ECSB) contracts with twelve agencies throughout the state to offer Child Care Resource and Referral (CCR&R) services. CCR&R agencies meet a need that no other agency does—they provide the bridge between parents, providers, community leaders and policy makers. By offering a unique blend of direct services and expertise, CCR&Rs help families and communities ensure that children enter kindergarten ready to succeed. They:

- — Take the guesswork out of finding and paying for child care.
- — Offer referrals to licensed and registered child care facilities for families of all income levels.
- — Offer child care assistance programs fro low-income families. (CCR&R agencies help more than 6,000 families find, evaluate, or pay for child care each year.)
- — Initiate projects that increase the supply of quality child care.
- — Offer training, technical assistance and support for child care providers.
- — Train more than 4,715 child care providers a year.
- — Help create child care solutions for communities.
- — Inform policy makers, businesses and the public on child care related issues.
- — Advocate for child care providers and for families with children.
- — Build brighter futures.

Child care referrals assist families with finding appropriate child care providers. The CCR&Rs maintain up-to-date, regional listings of regulated child care options. They are in daily contact with providers and maintain detailed, current information. CCR&Rs match a family's unique needs to the services providers offer. A referral specialist will work from a computerized database of child care providers to offer a family a listing of providers complete with hours of operation, location, ages of children served, cost, facility type and other services offered.

The referral agencies do not recommend one facility over another, but provide checklists, guidance, and assistance on selecting quality care, licensing regulations, parenting and child development information and payment assistance options.

In Montana, nearly 5,000 children under age five spend almost forty hours a week in child care. Clearly, child care can have a huge influence in growth and development. The quality of care children get in the first five years can affect them for the rest of their lives. It can also help prepare them to enter school with the skills they need to succeed.

Child care not only directly impacts children, it is expensive. All of us want to make sure we're making the very best investments possible. CCR&Rs assist families who are eligible for state-funded scholarships for child care. Typically, child care scholarships are available to families who are living on low incomes and working (or, in some cases, enrolled in school). If a family is eligible, the family pays part of the cost and the state pays the rest to the provider.

CCR&Rs also offer services to providers. They recruit new providers into the field of early care and education, assist new providers through the registration process to become licensed or registered by the State of Montana. They can explain the specific types of care needed and provide resource lending libraries to child care providers. These libraries offer equipment, resource materials, games, and activities for early childhood development to be "checked out" on a monthly basis.

The agencies also work with the local licensing specialists to present monthly orientation sessions for new providers and technical assistance to providers who have been referred by licensing specialists for corrective action. They develop and present regular training in the areas of child development, health and safety, infant and toddler care and sound business practices.

CCR&Rs support their local communities by serving as child care experts. They gather information regarding child care supply, demand, and costs, and offer service profiles. They also work with employers to develop family friendly work places.

Local CCR&Rs

Billings
District 7 HRDC
www.hrdc7.org

Bozeman
Child Care Connections
www.childcareconnections.info

Butte
Butte 4-C's
www.butte4-cs.org

Glasgow
Hi-Line Home Program CCR&R
www.hilinehomeprograms.org

Glendive
DEAP Child Care Resource & Referral
www.deapmt.org

Great Falls
Family Connections
www.famcon.org

Havre
District 4 HRDC-Child Care Link
www.hrdc4.org

Helena
Child Care Partnerships
www.childcare partnerships.org

Kalispell
The Nurturing Center
www.nurturingcenter.org

Lewistown
District 6 HRDC-Child Care Link
www.hrdc6.org

Miles City
DEAP Child Care Resource & Referral
www.deapmt.org

Missoula
Child Care Resources
www.childcareresources.org

What is Head Start?
(. . . and how is it different?)

—Mary Jane Standaert

There are many options for parents to choose from when it comes to the early education of a child, including private non-profit and for profit preschools, family child care homes, family group home child care, center-based child care, Head Start and Early Head Start programs. The basic difference between Head Start and Early Head Start and other early childhood programs is that Head Start and Early Head Start are federally funded programs designed to provide comprehensive services for low-income children and their families.

Head Start and Early Head Start are programs of the United States Department of Health and Human Services that provide free comprehensive education, health (medical, dental and mental), social and nutritional services for eligible low-income children. These programs are also designed to form and maintain partnerships with families and within local communities. Head Start was launched in 1965 as part of President Lyndon B. Johnson's *War on Poverty* to prepare children between the ages of three and five for kindergarten. In 1995, the Early Head Start program was established to serve pregnant women and children from birth to age three, recognizing that the earliest years matter a great deal in terms of a child's growth and development. Both programs strive to break the cycle of poverty by serving children and families with the goal of ensuring that children are ready to start (and succeed) in school.

Both programs are funded through federal grants that go directly to local community grantees. Both must adhere to Head Start Performance Standards, an extensive set of standards intended to make certain that each child and his/her family are receiving appropriate, high-quality services. All programs must have on-site federal program reviews every three years and complete annual self-assessments. Each program must conduct a full community needs assessment with multiple community partners. Teacher qualifications and staff training are seen as key to quality and are supported through a training and technical assistance network.

There are twenty Head Start and eight Early Head Start programs serving over 4,600 children and families in Montana. Seven Tribal Head Start programs and three Tribal Early Head Start programs are administered through the Office of Head Start Region XI American Indian Alaska Native Program Branch located in Washington, DC. There are also 13 non-tribal Head Start programs and five non-tribal Early Head Start programs statewide. The non-tribal programs are administered through the Region VIII Head Start Office located in Denver, Colorado.

Preschools, as described in state statute, are not regulated in Montana and are funded through private tuition. They provide partial-day educational services only. Child care programs (family, group and center based) are private businesses caring for and educating children of multiple ages while parents work or attend school. Child care programs can access subsidy dollars for low income children through the state office of the Early Childhood Services Bureau, but to do so, they must be licensed or registered with the Quality Assurance Division of the Montana Department of Public Health and Human Services. Even so, many programs operate outside licensing regulations. Licensing and registration require minimal standards for child care programs, which primarily address health and safety issues. Child care and preschool programs that wish to address quality go above and beyond minimum licensing standards by becoming accredited through a nationally recognized accreditation program.

No matter which early childhood program a parent selects or how it is funded, the most important aspect in optimal early childhood development is *relationships*. Children learn and develop best in healthy, positive relationships with adults. A quality early childhood education program starts with finding the right program for the parent and the child.

—Mary Jane Standaert is the Executive Director of the Montana Head Start/State Collaboration. She can be reached at 406-444-0589 or mjstandaert@mt.gov. For more information, visit www.headstartmt.org/AssnBus/collab.htm.

PREVENT

In February, Montana sent a team to the 2009 PREVENT Child Maltreatment Institute. The team is now working on a PREVENT pilot project. The primary goals include deepening the understanding of how to prevent child maltreatment before it happens, through planning, implementation, evaluation and sustainability of evidence-based prevention.

The Montana Team will work with the community of Havre because of its strong Early Child Investment Team, which includes all key partners. The focus will be strengthening the initial bonding and attachment between parents and young children.

The PREVENT Team will provide training for all home visiting staff in Havre, supply soft baby carriers for new parents and teach proper use. Parents will also gain specialized instruction and support. With targeted training and interventions, we hope to see reductions in emotional abuse and neglect in families who have children between the ages of prenatal and three. Ultimately, we hope that the project will serve as a model for attachment and bonding in early childhood settings across Montana.

Early Intervention:
Regional Part C Agencies

Regional Part C Agencies

An infant or toddler can be referred to a regional Part C agency by a parent, family member, doctor, nurse, daycare provider or other involved adult. These agencies can also be contacted with questions about Part C services.

Child Development Center (CDC) Missoula
(406) 549-6413, 1-800-914-4779
http://www.childdevcenter.org

Developmental Educational Assistance Program (DEAP), Miles City
(406) 234-6034 , 800-228-6034
http://www.deapmt.org

Early Childhood Intervention (ECI) Billings
(406) 247-3800

Family Outreach, Helena
(406) 443-7370
http://familyoutreach.org/

Hi-Line Home Programs, Inc. Glasgow
(406) 228-9431, 1-800-659-3673
http://hilinehomeprograms.org/

Quality Life Concepts, Inc. Great Falls
(406) 452-9531
1-800-761-2680
http://www.qlc-gtf.org

Support and Techniques for Empowering People (STEP), Billings
(406) 248-2055 , 1-800-820-4180
http://www.step-inc.org

When children are very young, we expect most of their needs to be met by their families, but when there are developmental delays or disabilities, it may be necessary to supplement what the family can do with professional help. Getting early outside help and support can help improve a child's development. Though it is sometimes difficult to think of infants and young children in terms of *education*, early training and therapy can make a tremendous difference by the time children go to school. The infant and toddler years are learning years for all young children, but for children with delays or disabilities, early learning takes on even greater importance. Skills like walking, talking, learning to feed, get dressed and getting along with others are often learned before age six. Some of these skills, such as language development, are best taught during the infant and toddler years.

Montana's *Part C Early Intervention Services* is a program under the Developmental Disability Program of the Department of Public Health and Human Services. It is provided for infants and toddlers (birth to 36 months) who have developmental delays or disabilities. Montana has seven regional Part C agencies that provide early intervention services for infants and toddlers. Services are based on the child's needs and the needs of the family. Once a child has been determined eligible, the services available to meet the child's and family's needs include the types listed in the table below.

Early identification, screening and assessment	Occupational therapy services	Parent and family education and counseling services
Special instruction	Physical therapy services	Home visits
Speech pathology and audiology services	Psychological services	Service coordination and social work services
Assistive technology devices and services	Health services necessary to benefit from early intervention services	Transportation and related costs
Vision services		Nutrition services

If a child is eligible, s/he may receive program services without cost to the family. However, if the child is eligible for Supplemental Security Income (SSI) or other similar programs (or if s/he has private health insurance), funds from these programs or insurance benefits must be used first, before Part C dollars come into play. Part C can make interim payments if there is an unacceptable delay in service provision. The program would then seek reimbursement from the responsible public or private source.

Some children leave Part C services before age three because they no long meet eligibility or have met age-appropriate milestones. Children who are still in services and about to turn three must transition out of Part C early intervention. Transition options are discussed with families, and might include a community preschool program, Head Start, homeschooling, or if eligible, special education services (Part B).

Part C Eligibility

Children from birth up to 36 months are eligible for early intervention and family support services under Part C of the Individuals with Disabilities Education Improvement Act (IDEA) if they:

1. Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay (e.g. sensory impairments, inborn errors of metabolism, microcephaly, fetal alcohol syndrome, epilepsy, Down syndrome or other chromosomal abnormalities), even though the delay may not exist at the time of diagnosis; or

— Are experiencing developmental delays (50% in one or 25% in each of two of the developmental areas). This is measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive or physical development, vision, hearing, speech and language development; social and emotional development and self-help skills.

An informed clinical opinion must be used when determining eligibility for services under Part C in the absence of standardized measures, or if the standardized measures and procedures are not appropriate for a given age or developmental level

—For more information, visit www. dphhs. mt.gov.

Hope for Families Living With Autism

—Jackie Emerson

—"When you take a drug to treat high blood pressure or diabetes, you have an objective test to measure blood pressure and the amount of sugar in the blood. It is straight-forward. With autism, you are looking for changes in behavior." —Temple Grandin

According to the Centers for Disease Control (CDC), autism is one in a group of disorders known as Autism Spectrum Disorders (ASDs). An ASD begins before age three and lasts throughout life. ASDs are developmental disabilities that cause substantial impairments in social interaction and communication, coupled with the presence of unusual behaviors and interests. The thinking and learning abilities of people with ASDs vary from gifted to severely challenged.

A 2007 report by the CDC revealed that the incidence of children born with autism was approximately 1 in 150 and increasing by an estimated 10-17 percent annually. In 2007, the National Institute of Mental Health reported that autism is the fastest growing developmental disorder, affecting more children than diabetes, cystic fibrosis, Down syndrome and cancer combined.

Parents now have access to such an overwhelming amount of information that can be as confusing and misleading as it is empowering. Autism impacts the entire family. Difficult—sometimes bizarre—behaviors make it challenging for family members to engage in the most ordinary, day-to-day activities, leaving them feeling isolated. Families trying to do what is best for the child are under a heavy strain emotionally, physically and financially. The divorce rate among the parents of autistic children stands at 70 to 80 percent, likely the result of living under tremendous stress.

The cause of ASDs is unknown. There are no medical tests to identify it, but there is hope in the form of intervention. According to reports from the American Academy of Pediatrics and the National Research Council, educational interventions that produce the best results are those that provide structure, direction and organization for the child. Interventions must be tailored to each child while taking overall developmental status, specific strengths and needs into account.

Some estimates suggest that it can cost about $3.2 million to take care of an autistic person over his or her lifetime and that the annual public healthcare cost to care for people with autism is in excess of $35 billion. In response, states are developing resources to fund services designed to teach children language, social interaction and daily living skills while reducing the inappropriate or problematic behaviors associated with autism.

The Montana Developmental Disabilities Program (DDP) under the Department of Public Health and Human Services, together with an Autism Taskforce, researched treatment strategies for persons diagnosed with autism or autism spectrum disorders. Research shows that a long-term increase in appropriate behaviors and commensurate decrease in inappropriate behaviors are possible with intensive early intervention and training that uses evidence-based interventions.

Early intervention coupled with very intensive training (often with a one-on-one staffing ratio) is effective, but costly. Even so, these costs may be more than offset if less assistance is needed as the child ages. Using this rationale, the DDP applied for and received approval for a Medicaid 1915c Waiver, following the example of states that provide children with very intensive, time-limited services, delivered at a very early age when behaviors are the most responsive to treatment.

When fully implemented, the Children's Autism Waiver will serve about 50 children. To be eligible for services and included on the waiting list, the child must be diagnosed with Autism Spectrum Disorder (ASD), have significant adaptive behavior deficits, and be between the ages of 15 months and 5 years. The child must be eligible for Medicaid, although parental income is not considered.

Children referred for Autism Waiver services will receive an initial screening. Those who are identified as potentially eligible through the screening process will be evaluated and diagnosed by professional clinicians. Eligible children are placed on a waiting list, and selected through a computer-generated random drawing as slots become available.

The intensive behavioral intervention services will typically be delivered 30-40 hours per week for a three-year period. Treatment strategies will be developed and directed by a DDP-certified behavior specialist, documented in an individualized family support plan, and provided by a direct support person with training and experience in providing behavioral support to children with autism. The Waiver will also include respite services to be used as crisis intervention as well as case management to provide service coordination.

Intervention services will be conducted primarily in the home, with parents and other family members taking active roles in all therapy components. The goal is to make parents the professionals in treating their children. Parents will be required to provide training for the child at least 10-15 hours per week so that at the end of the three-year program, parents will have the expertise to continue and sustain the child's gains.

Services provided will include case management, work with a behavior specialist, habilitation (for one-on-one training), training program and intervention, individual goods and services, professional therapy services, adaptive equipment/environmental modifications, transportation, and respite services. Services are expected to average approximately $40,000 per child per year, for a maximum service period of three years. National data indicates that this will be money well spent: with appropriate intervention, over a lifetime, this could yield cost savings of $1.7 to $2.8 million per person.

—Jackie Emerson is the Children's Autism Waiver Coordinator and Perry Jones is the Waiver Specialist for the Developmental Disabilities Program. For more information, visit: www.dphhs.mt.gov/dsd/ddp/autism.shtml.

The Unexpected Legacy: *Tobacco Smoke and Children*

—Sara Williams, VISTA and Patricia Nichols, M.A.

The U.S. Surgeon General's Report on secondhand smoke (2006) concluded that there is *no* risk-free level of exposure to secondhand smoke. Young and unborn children are especially vulnerable to the chemicals found in secondhand smoke, which often lead to problems with physical and psychological development. So, how can children remain safe from this common exposure?

While clean indoor air laws have led to the protection of large numbers of adults from secondhand smoke, these laws have not benefited children nearly as much because many are still exposed to secondhand smoke within their homes. According to a recent study, 34 percent of U.S. children still live in homes with at least one adult smoker. Furthermore, the children living below the federal poverty level are twice as likely to live with one adult smoker, and three times more likely to live with two or more. Household poverty and increasing numbers of adults in the home increase the chances that children will be exposed to secondhand smoke.

Unlike the delayed disease response that adults experience from smoking tobacco, babies and young people's health harms come early and may negatively impact physical and psychological health. Recent research has demonstrated that children exposed to secondhand smoke are at an increased risk of developing asthma, lower respiratory and middle era infections, and decreased lung growth and exercise tolerance. Also, pregnant women who are exposed to secondhand smoke are more likely to have babies with weakened lungs, lower birth weight, and a higher risk of experiencing sudden infant death syndrome (SIDS).

A new study published in March 2009 has linked behavior problem in young children regularly exposed to secondhand smoke. Those problems include, but are not limited to aggressive behavior, attention deficit hyperactivity disorder (ADHD) and conduct disorder

Tobacco addiction is not easily resolved, but there are steps we can take to protect young children who cannot protect themselves. It is no longer an expected social accommodation to allow smoking in the home. We recognize the risk and should request those who smoke to do so elsewhere. Secondhand smoke exposures that are less controllable when they arise as a result of living in apartments or other shared housing. In those cases, shared ventilation and common areas can transport the secondhand smoke and provide significant risks. Even the smoking residue from those who go outdoors to smoke is carried indoors. The toxins that cling to persons in close contact with tobacco smoke can also present risks.

Policies that protect families from exposure to secondhand smoke in multi-unit housing are being implemented by dozens of Public Housing Authorities, including the one in Helena. These policies not only reduce maintenance costs and fire risks, but create a healthy environment where children can grow.

The Montana Quit Line also provides free assistance and cessation support for those who use tobacco. For more information, call 1-800-QUITNOW.

Neonatal Smoking

Tobacco smoking during pregnancy is known to adversely affect development of babies' central nervous systems, restricting utero-placental blood flow and the amount of oxygen available to the fetus. Behavioral data associate maternal smoking with lower verbal scores and poorer performance on specific language/auditory tests.

Prenatal exposure to tobacco smoke is linked to various health, behavioral, and cognitive impairments. Some studies suggest that maternal smoking during pregnancy can lead to intellectual delays, most likely caused by central nervous system impairment, or can negatively affect language ability through underlying physiologic mechanisms (e.g., outer hair cells in the ear), thus leading to poorer performance on language-related tasks. One of the most consistent neurobehavioral findings is the association between maternal smoking and children's lower performance on arithmetic and spelling tasks, specific language and auditory tests, reading and language performance and verbal learning. At least one researcher observed that smoking ≥10 cigarettes/day during pregnancy was associated with greatly reduced babbling behavior in infants and almost doubled the risk of the infant not becoming a babbler by 8 months. Similarly, children prenatally exposed to smoking scored lower on standardized tests of language development at 3 and 4 years of age.

Source: MedXcape Today from Environmental Health Perspectives. Smoking During Pregnancy Affects Speech-Processing Ability in Newborn: Key, Ferguson, et. al. 4/27/2007. www.medscape.com/viewarticle/554844

Early Childhood Prevention through Afterschool Programs

—Julie Fischer

Statewide indicators and data suggest that communities need to implement prevention activities that will help prevent and/or delay substance abuse and violence among Montana's youth. Quality afterschool programs reduce risk factors and increase protective factors for at-risk youth of all ages. Quality afterschool programs provide supervision, offer enriching experiences and positive social interaction and improve academic achievement.

Afterschool programs provide Montana children with a safe, enriching environment during the hours immediately after school. One third of Montana's heads of household are single mothers with children who are age 18 and younger (33.2%); 64.9% of Montana families have both parents working outside the home. Between the hours of 3:00 and 6:00 P.M., youth are at greatest risk for engaging in juvenile crime and experimentation with tobacco, alcohol, drugs and sex. Juvenile crime rises during the hour immediately after the school day ends and violent juvenile crimes peak between 3:00 and 4:00 P.M., afterschool programs have more crime reduction potential than curfews.

Not all youth who are exposed to multiple risk factors become substance abusers, juvenile delinquents, teen parents or school dropouts. Risk factors are balanced by protective factors that reduce the impact of the risks or change the way a person responds. School opportunities and rewards for prosocial involvement are protective factors that promote positive behavior, health, well-being and personal success. Afterschool programs offer activities that include mentoring, computer instruction, college awareness and preparation, employment preparation or training, courses and enrichment activities in culture and the arts, youth leadership activities, and drug and violence prevention curricula. According to *After-School Programs: Keeping Children Safe and Smart* (2001), a joint report from the U.S. Department of Education and the U.S. Department of Justice, students in afterschool programs exhibit fewer behavioral problems, are better ability to handle conflict and have improved self-confidence.

Academic failure at the elementary school level and a lack of commitment to school are two risk factors that increase a student's risk for substance abuse, delinquency, teen pregnancy, school dropout, and violence. Afterschool programs often include homework assistance, tutoring, and supplemental instruction in basic skills such as reading, math, and science. Approximately 3,000 students did not graduate from Montana's high schools in 2007; the lost lifetime earnings in Montana *for that class of dropouts alone* are more than $799 million. Increasing the male high school graduation rates by just five percent would realize an annual crime-related savings of $10,637,756, additional annual earnings of $8,967,258 and create a total benefit to Montana's economy of $19,605,015. Afterschool programming is not limited to the primary grades. Elementary school students usually express prosocial attitudes, but those attitudes often change in middle school, when students come into contact with peers who participate in risky behavior. Favorable attitudes toward problem behavior are also linked to substance abuse, delinquency, teen pregnancy, and dropping out of school.

The afterschool hours represent an opportunity to invest in Montana youth to ensure greater academic success, increase youth protective factors, and ultimately contribute to Montana's economic growth. Early childhood prevention of alcohol, tobacco, and other drug experimentation can be fostered through quality afterschool programming.

—Julie Fischer is a Program Specialist for the Montana Board of Crime Control. She can be reached at 406.444.2056 or JFischer2@mt.gov.

Neurons to Neighborhoods

Neurons to Neighborhoods: the Science of Early Childhood Development identified three qualities that children need to be ready for school: intellectual skills, motivation to learn and strong socio-emotional capacity. Young children who develop strong early relationships with parents, family, caregivers and teachers learn how to pay attention, cooperate, and get along with others; they are confident in their ability to explore and learn from the world around them.

- *The longitudinal Abecedarian Research Project has shown that children entering school with well-developed cognitive and social skills are most likely to succeed and least likely to need costly intervention services later, such as special education and juvenile justice.*
- *Children dealing with early deprivation or trauma, family instability or conflict, involvement with the child welfare system, and limited resources, often experience problems in social-emotional functioning and delay in the acquisition of academic skills.*

Comprehensive, high quality investments in early education and development in the early years have demonstrated high monetary returns-on-investment-both to government and society in reduced social costs and increased economic activity and to the individuals serviced in improved education and economic status.

Neurons to Neighborhoods: the Science of Early Child Development is available online at http://books.nap.edu/catalog.php?record_id=9824#toc from the National Academies Press. http://books.nap.edu/catalog.php?record_id=9824#toc

We Need a Lighthouse

—Mary A. Musil, MS, RD

—We need a lighthouse that can guard us against obesity in our current environment. In truth, we may need many mechanisms to encourage better decision making about eating and exercise.

If we continue living the way we do, obesity rates will likely continue to rise. Few people will be able to avoid it, and there will not be enough money or health care to reverse it. A miracle cure seems unlikely.

A lighthouse is a device that guides ships as they enter and leave the harbor. It works perfectly the first day it is built and keeps right on working every day after that. It prevents sailors from danger so they travel can safely. It does this for big ships and small boats, and for local and international vessels alike. The lighthouse, once in place, operates effortlessly and costs almost nothing. Every ship that passes can use it successfully without further investment.

In Eric A. Finkelstein's new book *The Fattening of America, How the Economy Makes Us Fat, If It Matters, and What to Do About It*, he reviews the many reasons for obesity, as well as associated problems and costs. As it turns out, there is no single cause and no single solution. We have created a problem that we now own. "The ship has already left the shore," Finkelstein explains. There is no turning around.

Computers, i-pods and movies are here to stay. The same is true for elevators, baby strollers, TV, distance-learning, sedentary jobs, enormous stadiums, shopping malls, food and fashion magazines, refrigeration, bottled beverages, warehouse food stores, many kinds of restaurants, huge farm implements, automobiles, semi-trucks, interstate highways, fast trains and planes, drive-up services, new hospitals, on-line public services and marketing campaigns. Each and every one of these aspects of our lives are permanent—each also contributes, in one way or another, to eating more and exercising less.

Rates of overweight are climbing for Montana's citizens. The most striking aspect of this is the speed at which it is occurring. Within my lifetime, the obesity rate has gone from almost nothing to more than half of American adults. Many children are also affected, to the point that child care centers are asking how they should deal with the problem.

Given enough opportunity, incentive and promotion, few can stand up to the temptations of tasty foods and large portions. The young and the old, the rich and the poor, the educated and those less educated, the healthy and the sick, the motivated and the unmotivated—all find it more difficult to maintain a healthy weight. It is possible to mismanage or out-eat any diet plan, exercise goals, pill, medication or surgical solution.

The consequences of food and exercise decisions are too obscure to help ensure we make the right decisions. We can make *good* decisions some of the time, but not most of the time. Unfortunately, ti is most of the time that matters.

To prevent obesity, we have to make many deliberate changes in the economics of food, eating, exercise, education and the way we live. We have to believe these things matter.

We must remake our economy to prevent obesity. We need to make it *easier* to make good decisions about food and eating—for everyone, not just those who have education, resources and reasons to prevent obesity. This includes public laws, public food programs, award systems, businesses and workplaces, child care centers, cities, towns and parks, schools, teachers and health care providers, communications, farmers, gardeners and other food producers, food stores and restaurants, streets, roads and sidewalks, public transportation, park . . . planes, trains and automobiles. Every one of this exhaustive list contributes to the ability to make healthy decisions.

Since the problem of obesity can be difficult to reversible once present, we must prevent it for children. Children do not ask for excess weight. They grow up in environments that adults provide. We must create lighthouses that provide mechanisms to make it easier to eat better, eat less and exercise more. Our communities aren't healthy until all of us are healthy. We're in this together.

—Mary Musil has been employed by the Early Childhood Services Bureau in the Montana Department of Public Health and Human Services since July 2006. She can be reached at 406.444.4086 or mmusil@mt.gov.

Recommended reading:

— One book that works like a lighthouse for feeding children is A Child of Mine, *by Ellyn Satter, RD, MSW. The book provides insight and guidance for parents as they seek to feed themselves and their children, and her* Division of Responsibility *concept for feeding is relevant from birth on. She explains how parents can best be reasonable and responsible in the feeding of their children.*

— Satter, Ellyn, Child of Mine, Feeding with Love and Good Sense, *Bull Publishing Co., Boulder, Colorado, 2000. www.ellynsatter.com*

— Finkelstein, Eric A., and Zuckerman, Laurie, The Fattening of America, How the Economy Makes us Fat, If It Matters, and What to Do About It, *John Wiley & Sons, Inc., Hoboken, New Jersey, 2008.*

Strengthening Montana: *Best Beginnings*

—Governor Brian Schweitzer

Kindergarten opens the door for all children. I believe that all children are born ready to learn, and that it takes communities, parents, educators and business leaders to ensure that children get the best beginnings possible.

Investment in early childhood is not only good for Montana families but makes good economic sense for our state. That is why Montana has invested in full-time kindergarten.

The First Lady and I have a *Math and Science Initiative* that helps students discover opportunities in these two fascinating areas. I enjoying handing out the Math and Science trading cards to young children and watching them smile as they read about the facts and history about Montana.

To ensure all Montana students are prepared for the future I created the Kindergarten to College Workgroup that focuses on building a seamless education system in our state. That begins with ensuring kids are ready for school and continues to graduating all students ready for college and for work.

My administration believes that initiatives affecting Montana children, especially as they relate to education, are critical. By starting young with full time kindergarten, all children have the chance to be successful in today's and tomorrow's world.

I find it rewarding when I am traveling around Montana to stop and visit as many schools as possible. I like to read my favorite books, *When Charlie McButton Lost Power* or *First Dog, Unleashed in the Montana Capitol* to get children excited about reading. Feel free to contact my office at http://governor.mt.gov and invite me into your classroom!

Just Ask Anna

Dear Anna:

I need information on how to get a two-year-old baby out of a house where I suspect there is drinking and drug use going on. The dad gets drunk and has been known to pull knives on people during blackouts. The mother is nowhere to be found. I worry about the child's safety. I believe that it takes a village to raise a child. What should I do?

A Village Member

Dear Village Member:

I appreciate your concern. The Child Welfare League of America has reported that children whose parents abuse drugs or alcohol are three times more likely to be abused, and four times more likely to suffer from neglect. These children typically show greater adjustment problems, and have more behavioral conduct and attention-deficit disorders than children whose parents do not abuse substances.

Unfortunately, this is not an uncommon problem. In Montana, the Child and Family Services Division (CFSD) of the Department of Public Health and Human Services (DPHHS) administers child protective services, child abuse and neglect services, prevention services, domestic violence grants, and other programs designed to keep children safe and families strong. According to CFSD, in 2008, the Division received 14,969 reports of child abuse and neglect, 8,221 of which were investigated and 1,010 of which were substantiated. According to a point-in time report for June 30, 2008, on that one day there were 1,588 children in Montana's foster care placement system. Of those, the majority (60.4%) had parents who had drug or alcohol abuse issues.

My advice is to call the Child and Family Services Division's toll-free child abuse hotline, which operates 24 hours a day, 7 days a week. The CFSD provides protective services to abused, neglected and abandoned children. This involves receiving and investigating reports of child abuse and neglect, helping families stay together or reunite, and finding placements in foster or adoptive homes when necessary. The CFSD has the legal authority to interview the child, make emergency placements if a child cannot safely remain in the home, and take physical or legal custody when ordered to do so by the court. Ultimately, the priority is keeping children safe[3].

Sincerely,
Anna

Just Ask Anna is a new DPHHS *Prevention Connection Newsletter* column by Director Anna Whiting Sorrell. Articles will be focused on prevention and based on questions submitted through the DPHHS website *www.dphhs.mt. gov.*

To report a possible case of child abuse or neglect, call toll-free 1-866-820-5437. According to Montana law, the name of persons making the report must remain confidential. Anyone who believes that a child is being abused or neglected may report suspicions to the Hotline[2].

For More Information

1. The Economic Cost of Methamphetamine Use in Montana: a Report Prepared for the Office of the Attorney General. February 2009. *http://www.montana meth.org/*

2. Child and Family Services 101. Shirley K. Brown, CFSD Division Administrator. Winter 2006 Prevention Connection: Parenting and Families. Pages 12 – 13. NK "http://prevention.mt.gov/resource/prevconn/files/2006/prevconn_2006_ Winter.pdf" *http://prevention.mt.gov/resource/prevconn/files/2006/prevconn_2006_Winter.pdf*

3. Child and Family Services Division website: *http://www.dphhs.mt.gov/cfsd/*

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The Last Word

—Joan Cassidy

Sometimes the more things change, the more they stay the same. I recently came across an article by B. Sachs, M.D., published in the *Psychiatric Quarterly Journal* that stated, "In the attempt to prevent, or at least to curb the incidence of nervous and mental disorders throughout life, several factors of prime importance are to be considered: first, sound heredity; second, proper protection of the mother during pregnancy, and all possible care and skill at the time of the delivery of the child; third, sensible parents who have vision enough to guide the child carefully through the first years of life; fourth, rational school training, careful supervision during the adolescent years, the avoidance of sexual and alcoholic excesses, the avoidance of syphilitic infection."

If the language and some of the suggestions seems quaint, it is because the article was published in September 1928.

Research-based prevention bears out the importance of the majority of Dr. Sachs's advice. This issue of the *Prevention Connection* includes information from some of Montana's most prominent early childhood experts, articles discussing helping mothers protect fetal health during pregnancy, the importance of careful parenting in the early years and the long-term effects of a good education. Ultimately, all play important roles in our ability to help ensure that adolescents avoid some of the most dangerous teen risk behaviors and come out safely on the other side of childhood, ready to take their places in the ranks of productive community members.

According to the National Center for Children in Poverty (NCCP) based out of Columbia University, two decades of research have clearly established the detrimental impact of poverty and economic hardship on child development. Common risk factors include many of the concerns discussed in this issue, as well as poverty, food insecurity, poor parental physical and mental health, overcrowding and/or poor housing conditions and homelessness.

The NCCP stresses the importance of good policy consistent with what we know about the well-being of very young children and their families, particularly those living on low incomes. The NCCP believes the policies that affect early childhood development fall into three categories: health and nutrition; early care and learning; and parenting and economic supports. Montana is working hard at ensuring that these supports are in place for families. Ultimately, healthy early childhoods rife with opportunity, with books, relationships, safe routines, good nutrition, early childhood education, excellent health care and maternal supports will grow into what we have been working toward all along: healthy communities.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

2,500 copies of this public document were published at an estimated cost of $2.98 per copy, for a total cost of $7,460.00, which includes $3,460.00 for production and printing and $4,000.00 for distribution.